STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515140	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Health Care of Logan	1000 West Park Avenue Logan, WV 25601

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 31826 Based on observation and staff interview the facility failed to treat residents with respect and dignity during the dining experience and by pulling a resident down the hall backwards. These failed practices were random oppurtunities for discovery and had the potential to affect more than an limited number of residents currently resding in the facility. Resident Identifier # 36 Facility Census 111. Findings Include: a) Resident #36 An observation on 06/04/24 at 11:25 AM, of hall 400, revealed Nurse Aide (NA) # 58 pulling Resident #36 down the hallway backwards in a Geri chair about 30 feet. During an interview on 04/04/24 at 11:26 AM, NA #58 stated, This is the way I always do it. During an interview on 04/04/24 at 1:45 PM, registered Nurse (RN) #4 confirmed, staff should not be pulling residents backwards. b) Main Dining on 05/28/24 An observation of the main dining room for the evening meal on 05/28/24 found there was 24 residents seated in the dining room waiting for their meal at 6:00 PM. At 6:05 PM, Resident #70, #4, # 73, #6, and #59 were all served their meal. The remaining 19 residents were not immediately served their meal. At 6:20 PM the remaining 19 residents were served their meal. For 15 minutes 19 residents were watching the first five (5) residents eat their meal. One (1) resident was observed asking staff on multiple occasions where her food was. An interview with the activities staff who was working in the dining room indicated there is not usually a delay in the service of the meal. She stated, I don't know what is going on today. C) East Wing Dinner Service (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At approximately 5:37 PM on 05/28/24, during meal service on the East Wing of the facility, observations were made of staff serving different rooms instead of both residents in the same room, at the same time. Resident #99 was served at 5:37 PM while Resident #361 did not receive a tray. Staff continued to pull trays off of the delivery cart and take them to rooms without ensuring that both residents were served in the same room together. After the first delivery cart was empty, at 5:43 PM, Resident #361 still did not have a tray. At approximately 5:43 PM on 05/28/24, an interview was conducted with Licensed Practical Nurse (LPN) #26 regarding Resident #361 and why they had not received their tray yet, in which they stated We are just waiting on her tray, it should be on the next cart. Resident #361 received her tray at 5:50 PM, thirteen minutes after her roommate received their tray. At approximately 5:45 PM on 05/28/24, there were seven (7) residents prepared to eat in the lounge area on the East Wing of the facility. Five (5) residents were at one table while two residents sat at tables by themselves. At the table with 5 residents, two (2) residents were served their dinner trays, while three (3) of the residents did not receive their trays. The remaining 3 residents did not receive their trays until approximately 5:53 PM. At approximately 5:49 PM on 05/28/24, an interview was conducted with the Nurse Practitioner (NP) regarding the dinner service, as she was helping to pass trays. The NP stated This is not how this should go and it isn't how it usually goes. They all know the residents are to be served room by room and table by table. We will get it corrected. 49465 49467

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 45173 Based on observation and staff interview, the facility failed to safeguard the privacy of the back hall of the [NAME] wing resident's medical record. This was a random opportunity for discovery. Resident #83, #108, #97, #65, #60, #35, #98, #44, #45, #66, #68, #94, #66, #69, #30, #19, #58, #18, #3, #35, #96, #86, #80, #57, #10, #79, #53, #512, and #24. Facility Census: 111. Findings Include: a) [NAME] Wing Medication Computer On 05/29/24 at 9:45 PM, a tour of the facility was completed. Upon approaching the [NAME] wing medication computer on the back hall, the computer screen was visible with the resident's pictures and names. On 05/29/24 at 9:48 PM, Licensed Practical Nurse (LPN) #125 approached the cart and stated, I thought I locked the screen. On 06/04/24 at 1:00 PM, Registered Nurse (RN) #4 was notified of the computer screen being visible to anyone passing by the medication cart. RN #4 confirmed the computer screen should have been locked. RN # 4 stated, they told me what happened.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31826 Based on record review, resident observations and staff interviews the facility failed to ensure Resident #91 was free from nonconsensual sexual contact. In addition the facility failed to ensure Resident #75 was free from verbal abuse. The occurances with Resident #91 and Resident #75 both constituted an Immediate jeopardy (IJ) situation. The state agency (SA) determined the failure to protect Resident #75 from verbal abuse caused Resident #75 fear and anxiety due to verbal abuse from Licensed Practical Nurse (LPN) #28. At the time of the incident Resident #75 was unable to verbalize how this made her feel due to thinking the Facility administration would retaliate against them. Emotional and psychological abuse can have severe short- and long-term effects. This type of abuse can affect both your physical and your mental health. You may experience feelings of fear, confusion, anxiety, shame, guilt, frequent crying, and up to suicide or death. This action not only harmed Resident #75 but placed the remaining 110 residents in an IJ situation because LPN #28 was still employed at the facility and residents voiced fear of her. The facility was first notified of the IJ pertaining to Resident #75 at 2:09 PM, on 05/28/24. The state agency (SA) received the Plan of Correction (POC) at 5:00 PM on 05/29/24. The SA accepted the POC on 05/29/24 at 5:22 PM. The SA observed for the implementation of the POC and the IJ was abated on 06/04/24 at 4:23 PM. In regards to Resident #91 who suffers from end stage dementia and is rarely/to never understood. The staff found Resident #91 and Resident # 61 in bed together on 04/07/24. Through the course of their investigation, they contacted the healthcare decision maker who stated that it was okay and just a way of life and if both wanted to do it to let them have privacy to do it. After this conversation with the family member of Resident #91 the Social Worker stopped her investigation and the facility entered the following intervention on Resident #91's care plan: When resident is displaying sexual behavior and both resident and male resident are willing, Staff to provide privacy for residents, but if behavior is unwanted by either residents, staff to provide redirection. The results of the investigation were that no sexual abuse occurred. Interviews with the Social Worker, Nursing Home Administrator, and the Director of Nursing found none of the three was able to verbalize how Resident #91 was able to consent to sexual contact. They all indicated Resident #91 was seeking out Resident #61 and they felt that was her consent because she sought him out and sat on his bed. The behaviors exhibited by Resident #91 is consistent with her diagnosis of End Stage Dementia and does not constitute consent to sexual contact. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The facility's failure to assess Resident #61 for the ability to consent for sexual contact, combined with there thoughts of her consent being constituted by her wandering and setting on Resident #61's bed, and the care plan that indicates the family said if it was okay with both residents to provide them with privacy put Resident #91 in an immediate Jeopardy (IJ) situation. The facility was notified of this IJ at 10:57 am on 05/30/24. The State Agency (SA) accepted the facility's plan of correction (POC) at 4:01 PM on 05/30/24. After review of the implementation of the POC it was determined the IJ was abated at 4:23 PM on 06/04/24. Resident Identifiers: #91 and #75. Facility Census: 111. Findings Include: a) Resident #75 An interview with a Resident who wishes to remain anonymous due to fear of retaliation found they can hear LPN #28 coming and thinks lord please don't let her (staff #28) be in a bad mood. Anonymous resident states LPN #28 has a mean streak and I know my boundaries and stay away or just be quite and continued to say how they get upset and cry with fear of LPN #28. Resident # 75 stated on 05/29/24 at 10:45 AM, LPN #28 still yells a lot to other people and holds herself up to a higher standard. If LPN #28 has to supervise the resident smoke break. She states I hope yall know if someone dies it's your fault because I'm not there to help this statement was made last week. Resident # 75 also states they punish you around here like forgetting to feed you or answer the call light and will not give you a shower. On 05/30/24 at 11:56 AM Resident #21 stated she is concerned for the other residents in the facility. She can hear staff members yelling at them when they don't eat fast enough. On 5/28/24 at 10:00 AM, an interview with the Administrator regarding LPN #28 verbally abusing resident, the Administrator stated, she had been reported and investigated and taken care of. On 5/29/24 at 11:20AM, an interview with Director Of Nursing (DON) found, on a Thursday around May the 22 or 23 she was hiring some new nurses and let LPN #28 set in on the abuse and neglect part of the in service, and LPN #28 is scheduled to watch Abuse and neglect videos starting May31. A review of the facilities reportable on 5/29/24 at 9:00AM revealed Resident # 75 had an argument with Licensed Practical Nurse (LPN) # 28 on 05/08/24 at 11:00 AM. Further review of the facility reportable regarding Resident #75 Showed LPN #28 was verbally cussing at Resident #75 stating, I do my Fucking best to give all my residents the medication that they need a witness states she brought up how she has another resident on morphine and about to pass away, LPN #28 asked Resident #75 who was more important. Further review of witness statements from six(6) other staff members revealed the arguing between LPN #28 and Resident #75 went on for at least 20 minutes, Personal medical information regarding Resident #75 was revealed in front of everyone around during the time of the incident. LPN #28, wrote in her statement, she could have handled the situation better. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The facility did not substantiate this reportable saying the arguing and confrontation was not verbal abuse. LPN #28 was not suspended and is currently working at the facility. The following are the witness statements which were collected by the facility as part of the investigation: Certified Nursing Assistant Student #65 witness statement read: During smoke break @ 8:00 PM on May 7, 2024 I was outside with a few residents, they were smoking. A nurse started screaming at a resident. The resident just asked about her meds, the nurse told her she put them in the trash because she wouldn't take them. The resident said no, i just only wanted to take a couple because i haven't used the bathroom and I need something to make me go. The nurse(LPN#28) said no you take Melatonin, Rots, and some other pill, and told her the only reason she has trouble now is because she was shot and the reason was taken to the hospital because she had a fever of 104. This went on for about 20 mins. This happened not only in front of me but three other staff and seven or eight residents. But that wasn't the only resident she screamed at as there was a man in a wheelchair. Certified Nursing Assistant Student #77 witness statement read: Yesterday May 7, 2024 when we took smokers out around 8 Resident #75 was telling LPN #28 that she needed to stop taking one of her medications because it was making her constipate. LPN #28 then started yelling at Resident #75 telling her they would not have prescribed it to her if. Resident #75 told LPN #28 that the medication was causing her to end up in the hospital . LPN#28 yelled to Resident #75 that it was not the medication causing her to be constipated it was that damn gunshot wound that is making her have all the complications LPN#28 told Resident#75 she does her Fucking best to give all her residents the medication that they need. She brought up how she also had a resident who was on morphine and about to pass and asked Resident#75 who was more important. When we went back in LPN #28 said I getta go get Resident #75 a damn book. Certified Nursing Assistant Student #68 witness statement read: Yesterday, May 7, 2024. The residents were outside on a smoke break at around 8:00 PM While setting outside with them, a nurse (LPN #28) was outside as well. She was first speaking to (Resident #75), which resulted in (LPN #28) screaming at (Resident #75). (Resident #75) has just come in from the hospital as well. (Resident #75) had firstly refused her medication, later at the smoke break, (Resident #75) asked if she could have her medication, saying she had refused it because of her bowel issues. (LPN #28) proceeded to scream at (Resident #75), discussing her required medicine, her being shot and her refusal. She (LPN #28) was very unprofessional with (firstname Resident #75) discussing private things, private situations, and medications in front of all other residents on East Wing who smoke. (First Name)LPN #28 also cussed at (Firstname) Resident #75 while (LPN#28) was screaming. LPN #28 witness statement reads: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	This nurse(LPN#28) took resident(Resident #75) to smoke and resident(Resident #75) and this nurse and resident got into a shouting match this nurse(LPN#28) was wrong and has apologized to the resident(Resident #75). This nurse(LPN#28) will take care of the resident(Resident #75) as long as resident (Resident #75) is ok with it. Nurse(LPN#28) regrets causing resident (Resident #75) any issues. Trying to discuss medications with resident (Resident #75)resident(Resident #75) and nurse(LPN#28) discussed incident. Resident(Resident #75) and nurse(LPN#28) discussed incident resident incident and we are over it Certified Nursing Assistant Student #66 read: On May 7, 2024, I witnessed a nurse (first name)LPN#28 screaming at a resident named (first name) Resident #75 over medications. We were on our smoke break and (First name) Resident #75 had asked for a list of her medications and their side effects. (first name) LPN#28 freaked out at (Resident #75) and was yelling at her about how she had refused her meds and that she was not Digging them out of the garbage and Was not getting more out of the cart. (first name) LPN#28 also made sure to list out every medication that Resident #75 was on as well as bring up all of her medical issues due to being shot. There were 7 other residents outside at the time. This incident lasted roughly about 20 minutes and was very uncalled for. (first name) LPN#28 also cussed at her during this time (F-word - D- Word) Resident #75 statement read: We were having a shouting match, but I am over it. I was upset and didn't have anyone to take it out on. I know we didn't handle this very well. I don't feel like I was abused in any way. I'm fine with (first name) LPN# 28 working with me. b) Facility Plan of Correction for Verbal Abuse: Tag F 600 IJ Date: 5/29/2024 Time: 1409 1.) On 5/29/2024 the administrator, Director of Nursing and Human Resources Director terminated employee #28. On 5/29/2024 all staff were informed that all or any form of abuse or neglect toward a resident would result in immediate termination. 2.) Because this has the potential to affect all residents, on 5/29/2024 all residents were interviewed by administrative staff to ensure that they felt (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	safe and had never endured any type of abuse or neglect any residents unable to be interviewed were assessed for any visible signs of abuse or neglect during their stay at [NAME] Healthcare Services of [NAME] with any corrective action immediately upon discovery. 3.) The Director of Nursing and Social Worker has begun in-servicing ALL staff on 5/29/2024 about facility abuse and neglect zero tolerance policy and procedure and failure to comply resulting in immediate termination. All staff will be in serviced as of 5/29/2024 prior to their next shift, and virtually if need be. 4.) The Administrator will ensure adherence to the Abuse and Neglect Policy and Procedure, ensure that any employee who commits any act of abuse or neglect will be terminated immediately. The Social Worker will complete the log attached for all reports of abuse and neglect and turn the log in to the Administrator each time a complaint is made so the Administrator can handle corrective action of the staff immediately. To ensure continued compliance, the monitoring log will be re-evaluated. c) Resident #91 A review of a Facility Reported Incident which was received by the state agency on 04/07/24 found the following: Type of Incident was a resident to resident incident. The type of abuse was specified as Sexual. The incident form indicated the the staff became aware of the abuse at 9:00 AM on 04/07/24. Resident #91 was listed as the alleged victim. The perpetrator was listed as Resident #61. The reportable listed four (4) staff members as witnesses to the incident. The staff were identified as QA #66, Licensed Practical Nurse (LPN) #105. Restorative Aide #102, and Prior Employee # 1 (Position unknown), The incident report indicated the residents were witnessed in lying in bed in a sexual position. The place was indicated it was Resident #61' bed. A review of the facility's five day follow up report found the following information: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	.2. steps taken to investigate the allegation: Provide a detailed summary of ALL steps taken to investigate the allegation. Summary of Interviews with the alleged victim and/or the victims responsible party, if applicable. Indicate any visual cues from the resident of psychosocial distress. (The facility's response) No suspicion of abuse or neglect. Resident to Resident No Harm. Summary of Interviews with witnesses including but not limited to, what the individual observed or knowledge of the alleged incident or injury: (Facility Response) None. Summary of Interviews with the alleged perpetrators identifying whether they are staff, resident, visitor, contractor, etc. (facility response) None. Summary of Interviews with other residents who may have had contact with the alleged perpetrators: (Facility Response): None. Summary of Interviews with staff responsible for oversight and supervision of the location where the alleged victim resides (Facility Response) Residents were separated, and educated about sexual contact with other residents. Summary of the interviews with staff responsible for oversight and supervision of the alleged perpetrator if the perpetrators staff or a resident: (Facility Response) see above. Provide Summary information from the investigation related to the incident from the residents clinical record as relevant portions of the RAI, the residents care plan, nurses' notes. social service note, lab reports, x-ray reports, physician or other practitioner reports, or reports from other disciplines that are related to the incident. If a resident to resident altercation occurred provide any relevant details that may have caused the alleged perpetrators behavior, such as habits, routines, medications, diagnosis, how long he/she may have lived at the building, or BIMS score. (facility response): none. If available within the five working day timeframe provide summary of information of other documents obtained, such as hospital/medical progress notes/orders and discharge summaries, law enforcement reports and death reports if applicable. (facility Response) None. 3. Conclusion Provide a brief description of the conclusion of the investigation and indicate if findings were: (For incidents reported as injuries of unknown source indicate if the injury resulted from abuse or neglect, based on evidence from the investigation) Verified: The allegation was verified by evidence collected during the investigation. Indicate how the allegation was verified by evidence collected during the investigation and describe the evidence. (Facility Response) No abuse or neglect. Not Verified: The allegation was refuted by evidence collected during the investigation. Indicate and describe why the allegation was unable to be verified during the investigation. (Facility Response) No Abuse or neglect (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Inconclusive: The allegation could not be verified or refuted because there was insufficient information to determine whether or not the allegation had occurred. If this incident was identified as inconclusive, indicate and describe how this was determined. (Facility Response) No abuse or neglect. 4. Corrective action taken: Provide in detail a summary of all corrective action taken. Describe any actions taken as a result of the investigation or allegation. (Facility Response) Residents were separated and educated about sexual contact with other residents. Describe the plan for oversight of the implementation of the corrective action, if the allegation is verified (Facility Response) Staff will provide oversight and monitor the residents for further contact. As a result of of a verified finding of abuse such as physical, sexual, or mental abuse, identify counseling or other intervention planned and implemented to assist the resident (Facility Response) None . An interview with the Social Worker on 05/29/24 regarding the incident that took place on 04/07/24 found she did not take statements from any of the staff because they had contacted the healthcare decision maker, and she basically said it was okay as long as the resident wanted to do it. She stated, she went to his room and sought him out. The social worker continued to state, She wanders in and out of rooms every day, but she always seems to go to his room. She then stated, she must like him. When asked if Resident #91 was able to give consent to sexual contact she said, Well she wanders into his room and gets in his bed so I guess that means she wants it. She stated, It was not abuse or neglect because the healthcare decision make said as long as both people want it then to let it happen. An interview with the Director of Nursing on the afternoon of 05/29/24 revealed she had called the residents healthcare decision maker and the healthcare decision maker stated that it was just a way of life and if they were both okay with it then to just give them privacy. The DON indicated this is the reason they did not consider this sexual abuse. When asked if Resident #91 was able to give sexual consent the DON indicated the resident seeks out Resident #61 and that is what they are basing her consent on. The DON acknowledged the resident has dementia so she stated there are days she will smile, and the resident will sometimes respond to her name. When the DON was asked if Resident #91 was able to find Resident #61's room consistently even though she at times does not even know her own name. She stated, Yes I ' m sorry but she can. An interview with LPN #135 on 05/29/24 at 12:47 PM, confirmed she had witnessed the residents in bed together on 04/07/24. She stated, Resident #91 was in the male resident's room and they were laying on the bed beside each and were interlocked in a sexual position. She stated that she separated them and called the NH and SW. When asked how Resident #91 was acting she stated she had no emotion on her face which is normal due to her dementia. She stated Restorative aide #102 and QA #66 was the nurse aides that told her about the incident. A review of Resident #91's medical record found a Minimum Data Set (MDS) with an assessment reference date (ARD) of 12/18/24 and 03/15/24 both of which indicate the resident is rarely to never understood. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The residents diagnosis include: Unspecified dementia, Unspecified severity, with other behavioral disturbance. Resident #91's careplan contained the following focus statement: The resident has increased sexual inhibitions / behavior r/t -Has been striping (SIC) in front of males -Getting into bed with male residents -Touching males in private areas -Allowing male resident to to touch her -Family is aware and stated they wanted the facility to do what is best for both residents, if both resident are willing, to provide privacy for residents, but if behavior is unwanted by either resident, to provide redirection. -uses the medication Tagamet to reduce libido. The interventions included: When resident is displaying sexual behavior and both resident and male resident are willing, Staff to provide privacy for residents, but if behavior is unwanted by either residents, staff to provide redirection. This intervention was added to Resident #91's care plan on 04/12/24 which was five (5) days after the incident on 04/07/24. On 05/30/24 at 8:52 a phone interview with Resident #92's healthcare decision maker found the facility had called and she stated, My brother and I talked about it and told them to just let happen, because how are they going to stop it. When asked if this was her mother's lifestyle prior to her dementia she stated, when she turned 50, she divorced my dad and turned this way. I know she is probably the aggressor. She stated, I do not think it is bothering her in any way. According to the state operations manual (SOM) page 76 the following pertains to an appointed decision maker: While a legal representative may have been empowered to make some decisions for a resident, it does not necessarily mean that the representative is empowered to make all decisions for the resident. The individual arrangements for legal representation will have to be reviewed to determine the scope of authority of the representative on behalf of the resident. A review of the resident's record found the residents daughter was appointed as Durable Power of Attorney on 03/18/14 and this appointment gave her daughter the right to make all financial decisions and medical decisions if Resident #91 was deemed incapacitated to do so. The medical record contained, and incapacity statement dated 08/11/23 which the resident's physician stated the resident does not have capacity to make healthcare decisions due to end stage dementia. (continued on next page)

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	515140	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Health Care of Logan	1000 West Park Avenue Logan, WV 25601

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	According to the SOM page 77 the following pertains to sexual consent: The legal standards and criteria for sexual consent vary across states ([NAME], 2007; [NAME] et al., 1999). The most widely accepted criteria, which are consistent with those applied to consent to treatment, are: (1) knowledge of relevant information, including risks and benefits; (2) understanding or rational reasoning that reveals a decision that is consistent with the individual's values (competence); and (3) voluntariness (a stated choice without coercion). An interview with the Nursing Home Administrator (NHA) at 10:15 PM on 05/30/24, found she thought it was the residents right to have sexual contact if they wanted to. She stated, We felt, (Name of Resident #91) seeks out this resident and climbs in bed with him and gets mad when we try to redirect her. She further stated, Her daughter told us she use to like black men. She then stated, Maybe she walks by his room and sees he is black and wants to be with him. She then stated, the nurse aide who showers him said he never gets hard (a slang term used to indicate an erection), so I know they have never had sex. The SOM on pages 75 to 76 says this in regards to Sexual Abuse: Sexual abuse is non-consensual sexual contact of any type with a resident, as defined at 42 CFR S483.5. Sexual abuse includes, but is not limited to: o Unwanted intimate touching of any kind especially of breasts or perineal area; o All types of sexual assault or battery, such as rape, sodomy, and coerced nudity; o Forced observation of masturbation and/or pornography; and o Taking sexually explicit photographs and/or audio/video recordings of a resident(s) and maintaining and/or distributing them (e.g. posting on social media). This would include, but is not limited to, nudity, fondling, and/or intercourse involving a resident. Generally, sexual contact is nonconsensual if the resident either: o Appears to want the contact to occur, but lacks the cognitive ability to consent; or o Does not want the contact to occur. Other examples of nonconsensual sexual contact may include, but are not limited to, situations where a resident is sedated, is temporarily unconscious, or is in a coma. Any investigation of an allegation of resident sexual abuse must start with a determination of whether the sexual activity was consensual on the part of the resident. A resident ' s apparent consent to engage in sexual activity is not valid if it is obtained from a resident lacking the capacity to consent, or consent is obtained through intimidation, coercion or fear, whether it is expressed by the resident or suspected by staff. Any forced, coerced or extorted sexual activity with a resident, regardless of the existence of a pre-existing or current sexual relationship, is considered to be sexual abuse. A facility is required to conduct an investigation and protect a resident from non-consensual sexual relations anytime the facility has reason to suspect that the resident does not wish to engage in sexual activity or may not have the capacity to consent. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Prior to surveyor intervention the facility failed to evaluate Resident #91 and Resident #61 for the ability to consent to sexual contact. As part of the Plan of Correction the facility evaluated all residents for the ability to consent to sexual contact. A review of Resident #91's and Resident #61's assessment found both lacked the capacity to consent to sexual contact. An interview with the Chief Operating Officer (COO) and the Quality Assurance director at 3:00 PM on 06/03/24 found the facility felt no sexual abuse had occurred. The COO stated we never provided them with privacy eventhough it was in the care plan. He asserted he felt this should not even be a citation. When asked why his DON, NHA, and Social Worker all indicated in their interviews that Resident #91 sought out Resident #61 and that indicated she wanted him and wanted to have sexual contact with him. The COO stated, I think they are just scared for their jobs and was looking at it as a resident rights issue and was trying to say what they thought they needed to say. d) Plan of Correction Tag F 600 IJ Date: 5/30/2024 1.) On 5/30/2024 the administrator assigned 1:1 staffing at all times for resident #91 to ensure she is free from non-consensual sexual acts. On 5/30/2024 all staff were informed that all residents are to be kept free from non-consensual sexual harm despite their mental capacities. 2.) Because this has the potential to affect all residents, on 5/30/2024 all residents were interviewed by administrative staff to ensure that they had never been subject to non-consensual acts of sexual nature during their stay at [NAME] Healthcare Services of [NAME] with any corrective action immediately upon discovery. 3.) The Director of Nursing and Social Worker has begun in-servicing ALL staff on 5/30/2024 about facility ' s policy and procedure about resident engaging in sexual acts and what is prohibited. All staff will be in-serviced as of 5/30/2024 prior to their next shift, and virtually if need be. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from medications that restrain them, unless needed for medical treatment. 49467 Based on record review and staff interview, the facility failed to ensure each resident was free from chemical restraint. Resident #27 was given an antipsychotic injection before showers, to prevent the resident from becoming combative during the shower. This was true for one (1) of one (1) residents reviewed for chemical restraints during the survey process. Resident identifier: 27. Facility census: 111. Findings include: A) Record review At approximately 2:22 PM on 05/30/24, a record review was conducted of medication regimen reviews for Resident #27. During this review, the recommendation made on the review for May of 2023 was for Ziprasidone. The recommendation stated the diagnosis of dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance should be changed to be more specific, or the medication should be discontinued. The order for the medication read: Geodon Intramuscular Solution Reconstituted (Ziprasidone Mesylate) Inject 10 mg intramuscularly every day shift every Tue, Thu, Sat for Dementia with psychotic features administer 10mg injection IM x 1 20 min prior to shower. A review of the MAR for Resident #27 revealed she received the injection on the following days: -05/20/23 -05/23/23 -05/25/23 -05/27/23 -05/30/23 -06/01/23 -06/03/23 -06/06/23 -06/08/23 -06/10/23 -06/13/23 (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-06/15/23 -06/20/23 -06/22/23 -06/24/23 -06/27/23 -06/29/23 -07/01/23 -07/04/23 -07/06/23 -07/08/23 -07/11/23 -07/13/23 -07/15/23 -07/18/23 B) Staff interviews At approximately 3:43 PM on 06/03/24 an interview was conducted with the Director of Nursing (DON) regarding the order for Ziprasidone to be given to Resident #27 before her showers. The DON stated That is the only way we could get her in the shower. She was combative, she would hit and scratch the staff, she was going to hurt herself or someone else if we didn't give it to her.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 45173 Based on record review and staff interview, the facility failed to report an allegation of verbal abuse for Resident #22 and a bruise on Resident #93. This was a random opportunity for discovery. Resident Identifier: #93 and #22. Facility Census: 111. Findings include: a) Resident #93 On 06/03/24 at 12:22 PM a record review of Resident #93's progress notes found the following note: 5/16/2024 08:14 Nurses Note Note: This nurse entered the resident's room to medicate the resident with her morning meds. When the resident turned around to face this nurse, a bruise under her eye was noticed. When asked what happened the resident explained that, I bumped it off the cabinet when I bent over to put my things away. This nurse asked the resident if she felt any pain of discomfort to which the resident reported she wasn't hurting and she did not know she was bruised until this nurse asked about it. Physician Notified If Needed: Physician Orders if Needed: Responsible Party Notified If Needed: first name (Emergency Contact-daughter-in-law) was contacted, first name (Son) is unavailable at work at this time. first name (Emergency Contact-daughter-in-law) said, Thank you for calling us to let us know. Further review of Resident #93's medical record found she had a Brief Interview of Mental Status (BIMS) of 3 which indicates she is severely cognitively impaired. The record indicated she has short term memory loss and a diagnosis of dementia. On 06/03/24 at 1:15 PM the Social Worker was asked for the reportable in regard to the bruise on Resident #93's eye. The Social Worker stated, they did not report it because it wasn't harm and the administrator chimed in stating the nurse witnessed the resident hit it on the door knob. On 06/03/24 at 1:55 PM, an interview with Licensed Practical Nurse (LPN) #37 found he did not see her hit her eye on anything, he walked into the room and noticed a dark bruise under eye, he then asked the resident where did you get that bruise under your eye Resident #93 told him oh I hit it on my drawers LPN #37 states she rummages and goes through her draw a lot. b) Resident #22 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/04/24 at 1:21 PM, a record review was completed for Resident #22. The review found a progress note dated 05/20/24 at 8:10 PM which stated, This nurse was out on smokers porch with this resident, resident noted to be agitated, talking about leaving tomorrow, sneaking out the fire exit, made accusations against male staff. States He told me if I didn't sleep with him he'd rape me. Resident noted to be muttering to self more this shift, talking to people who aren't there. Attempts at redirection unsuccessful x (times) 3 (three). This progress note was documented by Licensed Practical Nurse (LPN) #28. An interview with Social Worker (SW) #17 was held on 06/04/24 at 1:00 PM. SW #17 stated, I didn't know anything about it .should I report now? (Name of LPN #28) did not report it to anyone. On 06/04/24 at 1:20 PM, an interview was held with Chief Operating Officer #140 and Quality Assurance Director #141, both confirmed this allegation should have been reported. On 06/04/24 at 3:10 PM, an interview was attempted with Resident #22. Resident #22 stated, I'm going to smoke do you want to come with me? The staff assured the resident, she would be able to smoke. The resident was asked has anyone ever been inappropriate with you? The resident responded what do you mean? Has anyone been verbally or physically abusive? Has anyone every touched you inappropriately? The resident responded, no .I'm ready to go smoke now. No further information was obtained during the survey process. 49751

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 31826 Based on record review and staff interview the facility failed to thoroughly investigate an allegation of sexual abuse involving Resident #91 and Resident #61. This was true for two (2) of six (6) residents reviewed for the care area of abuse during the long term care survey process. Resident Identifiers: 91 and 61. Facility Census: 111. Findings Include: a) Resident #91 and #61 incident date 04/07/24 A review of a Facility Reported Incident which was received by the state agency on 04/07/24 found the following: Type of Incident was a resident to resident incident. The type of abuse was specified as Sexual. The incident form indicated the the staff became aware of the abuse at 9:00 AM on 04/07/24. Resident #91 was listed as the alleged victim. The perpetrator was listed as Resident #61. The reportable listed four (4) staff members as witnesses to the incident. The staff were identified as QA #66, Licensed Practical Nurse (LPN) #105. Restorative Aide #102, and Prior Employee # 1 (Position unknown), The incident report indicated the residents were witnessed in lying in bed in a sexual position. The place was indicated it was Resident #61' bed. A review of the facility's five day follow up report found the following information: .2. steps taken to investigate the allegation: Provide a detailed summary of ALL steps taken to investigate the allegation. Summary of Interviews with the alleged victim and/or the victims responsible party, if applicable. Indicate any visual cues from the resident of psychosocial distress. (The facility's response) No suspicion of abuse or neglect. Resident to Resident No Harm. Summary of Interviews with witnesses including but not limited to, what the individual observed or knowledge of the alleged incident or injury: (Facility Response) None. Summary of Interviews with the alleged perpetrators identifying whether they are staff, resident, visitor, contractor, etc. (facility response) None. Summary of Interviews with other residents who may have had contact with the alleged perpetrators: (Facility Response): None. Summary of Interviews with staff responsible for oversight and supervision of the location where the alleged victim resides (Facility Response) Residents were separated, and educated about sexual contact with other residents. Summary of the interviews with staff responsible for oversight and supervision of the alleged perpetrator if the perpetrators staff or a resident: (Facility Response) see above. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide Summary information from the investigation related to the incident from the residents clinical record as relevant portions of the RAI, the residents care plan, nurses' notes. social service note, lab reports, x-ray reports, physician or other practitioner reports, or reports from other disciplines that are related to the incident. If a resident to resident altercation occurred provide any relevant details that may have caused the alleged perpetrators behavior, such as habits, routines, medications, diagnosis, how long he/she may have lived at the building, or BIMS score. (facility response): none. If available within the five working day timeframe provide summary of information of other documents obtained, such as hospital/medical progress notes/orders and discharge summaries, law enforcement reports and death reports if applicable. (facility Response) None. 3. Conclusion Provide a brief description of the conclusion of the investigation and indicate if findings were: (For incidents reported as injuries of unknown source indicate if the injury resulted from abuse or neglect, based on evidence from the investigation) Verified: The allegation was verified by evidence collected during the investigation. Indicate how the allegation was verified by evidence collected during the investigation and describe the evidence. (Facility Response) No abuse or neglect. Not Verified: The allegation was refuted by evidence collected during the investigation. Indicate and describe why the allegation was unable to be verified during the investigation. (Facility Response) No Abuse or neglect Inconclusive: The allegation could not be verified or refuted because there was insufficient information to determine whether or not the allegation had occurred. If this incident was identified as inconclusive, indicate and describe how this was determined. (Facility Response) No abuse or neglect. 4. Corrective action taken: Provide in detail a summary of all corrective action taken. Describe any actions taken as a result of the investigation or allegation. (Facility Response) Residents were separated and educated about sexual contact with other residents. Describe the plan for oversight of the implementation of the corrective action, if the allegation is verified (Facility Response) Staff will provide oversight and monitor the residents for further contact. As a result of of a verified finding of abuse such as physical, sexual, or mental abuse, identify counseling or other intervention planned and implemented to assist the resident (Facility Response) None . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Social Worker on 05/29/24 regarding the incident that took place on 04/07/24 found she did not take statements from any of the staff because they had contacted the healthcare decision maker, and she basically said it was okay as long as the resident wanted to do it. She stated, she went to his room and sought him out. The social worker continued to state, She wanders in and out of rooms every day, but she always seems to go to his room. She then stated, she must like him. When asked if Resident #91 was able to give consent to sexual contact she said, Well she wanders into his room and gets in his bed so I guess that means she wants it. She stated, It was not abuse or neglect because the healthcare decision make said as long as both people want it then to let it happen. An Additional interview with the social worker in the afternoon of 06/04/24 found she did not take witness statements because the Licensed practical Nurse is the one who filled out the report. When asked about the three (3) additional employees she stated, they just heard about what happened and was not actual witnesses. She stated, they are hear I will get their statements now. The social worker then exited the room. Later in the afternoon on 06/04/24 the social worker provided two (2) hand written statements from QA #66, and Restorative Aide #102. The statements were as follows: QA #66 wrote: '(Typed as written including misspellings) (Name of Resident #91) was wondering and no one knew were she was I went into (First Name of Resident #61)'s room to get his tray and seen (First Name of Resident #61) on top of (First Name of Resident #91) I couldn't leave the residents so I stood by the door and hollered for the closest person which was (First Name of Restorative Aide #102) and (First Name of Licensed Practical Nurse # 105) came they got their clothes back on and directed (First name of Resident #91) to her room. Restorative Aide #102 wrote: (Typed as Written including misspellings) I witnessed (First Name and Last Initial of Resident #91) and Mr. (Last name of Resident #61) trying to engage in sexual activity. I requested the nurses to come and assist and we got them separated and back to their respected rooms and beds. Mr, (Last Name of Resident #61) did have his pants and underwear down and Mrs. (First name of Resident #91) too, but I didn't see if he had made it inside. I helped separate them then reported it. When separating Miss (First name of Resident #91) tried to fight against us due to confusion, but we got her dressed and no problems after that. Mr. (Last Name of Resident #61) co-op completely during it. The surveyor completed an interview with LPN #135 on 05/29/24 at 12:47 PM, she confirmed she had witnessed the residents in bed together on 04/07/24. She stated, Resident #91 was in the male resident's room and they were laying on the bed beside each and were interlocked in a sexual position. She stated that she separated them and called the NH and SW. When asked how Resident #91 was acting she stated she had no emotion on her face which is normal due to her dementia. She stated Restorative aide #102 and QA #66 was the nurse aides that told her about the incident. All three (3) of the witnesses demonstrated they had witnessed the incident on 04/07/24, but the Social Worker failed to obtain statements from them until after surveyor intervention.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31826 Based on record review and staff interview the facility failed to provide the resident and/or responsible party an accurate bed hold policy upon discharge from the facility. This was true for one(1) of six (6) residents reviewed for the care area of hospitalization s during the long term care survey. Resident Identifier: #57. Facility Census: 111. Findings Include: A) Resident #57 A review of Resident #57's medical record found she went to the hospital on 02/11/24 at which time the facility was at bed hold capacity. The resident returned to the facility on [DATE]. She used a total of three (3) of her 12 medicaid bed hold days for this hospital stay. Resident #57 was again discharged to the hospital on 02/19/24 at the time of this discharge the facility issued a bed hold notice the residents responsible party which indicated they were at bed hold capacity and Resident #57 still had 12 medicaid bed hold available for the year. An interview with the business office manager at 1:44 PM on 06/04/24 confirmed the resident only had nine (9) bed hold days left on 02/19/24 and the bed hold notice was wrong. She indicated they do pull it up on the computer when they call them and tell them the correct number but that was not reflected on the bed hold notice.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 31826 Based on record review and resident and staff interview, the facility failed to ensure care plans were developed/implemented for each resident due to hydration interventions not being implemented for Resident #27, Activities visits not being developed for Resident #6, and fall interventions not being implemented for Resident #65. This was true for three (3) of 32 residents reviewed for care plans during the survey process. Resident identifiers: 27, 6, 65. Facility census: 111. Findings include: A) Resident #27 At approximately 2:43 PM on 05/28/24 an interview was conducted with Resident #27. She stated I don't get juice and snacks like I used to. My mouth is so dry, it feels like I'm spitting cotton. Resident #27 was asked if facility staff passed water and ice on a daily basis, to which they stated No, they don't pass it. No water pitcher was witnessed within reach of Resident #27. Upon further investigation, no water pitcher was found in Resident #27's room. Another observation of Resident #27's room at approximately 12:51 PM on 05/29/24 revealed no water pitcher was present in the room. At approximately 10:00 AM on 05/30/24 another observation of Resident #27's room revealed no water pitcher was present in the room. At approximately 4:50 PM on 05/30/24, an observation of Resident #27's room revealed no water pitcher was present in the room. A review of the care plan for Resident #27 revealed she is at risk for dehydration. The care plan states the following as a focus: The resident has dehydration or potential fluid deficit r/t (related to) N/V (nausea/vomiting) at times. The goal for this focus is: The resident will be free of symptoms of dehydration and maintain moist mucous membranes, good skin turgor. Listed under interventions and tasks is: Encourage/Cue resident to drink all fluid on meal tray and participate with juice wagon. At approximately 5:17 PM on 05/30/24, The Director of Nursing (DON) accompanied this surveyor to Resident #27's room and acknowledged the absence of a water pitcher. An interview was then conducted with the DON regarding the absence of a water pitcher in Resident #27's room. The DON stated I don't know if she can hold the regular water pitchers. When the DON was informed there were no orders for adaptive equipment for Resident #27, she stated I'm not sure then, I would have to get back to you. b) Resident #6 On 05/28/24 at 3:20 PM resident said she likes to have people to talk too and she likes to listen to people sing asked if she ever goes to listen to them sing she said no-one has ever asked her about that. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/29/24 at 03:50 PM, the activity of singing was going on in the Dining area while Resident #6 remained in bed in her room with her roommate During staff interview on 05/30/24 at 2:08 PM, the activity director states Resident #6 is scheduled for in room visits daily. Further record review on 05/30/24 revealed the following activity notes: 2/3/2024 13:46 Activities Note Note Text: Weekly Activity Visit 2/3/24: resident is alert and verbal with confusion. Activity staff visited with resident in room for activity. Activity consist of nail care. Resident did participate in activity. Resident also picked out her own color that she wanted to her nails painted. Activity staff will continue to visit, and invite/ encourage resident to participate in all upcoming activities. Staff reminded and showed resident where monthly activity calendar will hang in room. 1/9/2024 15:05 Activities Note Note Text: Activities Annual Note 1/9/2024: Activity annual assessment has been reviewed, revised and completed. Resident is alert and verbal with confusion. Resident did participate in interview and answered all questions on assessment to the best of her ability. Activity annual assessment has been completed During an interview with the Activity Director on 05/30/24 at 2:24 PM When asked about coming to the activity she states she hurts to bad to come to the activity, we do visits 2 to 3 times a week and the Activity Director confirmed the care plan did not say / contain how many activity visits were to be done weekly. c) Resident #65 A review of Resident #65's care plan on the afternoon of 05/28/24 found the following care plan related to fall prevention: Focus Statement Read: - The resident is at risk for falls r/t (Related To) -Not aware of safety needs -H/O (History of) falls at home was in floor on 12/12/23 in floor 3/10/24 was off matt in floor slid out of chair on 3/18/24 Date Initiated: 11/21/2023 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Revision on: 03/19/2024 The goal related to this focus statement read as follows: --The resident will be free of falls through the review date. Date Initiated: 05/14/2024 Revision on: 05/17/2024 Target Date: 08/15/2024 The Interventions related to this goal included: -- Safety mat to bilateral side(s) of bed d/t safety precaution, risk of falls. Date Initiated: 12/19/2023 Revision on: 12/29/2023 -- Dycem to w/c at all times to prevent sliding. Date Initiated: 05/28/2024 -- Alarm to chair while in chair. Observe and report to nurse Adverse consequences of alarm use which can include, but are not limited to: fear, anxiety, or agitation related to the alarm sound; decreased mobility; sleep disturbances; and infringement on freedom of movement, dignity, and privacy -- Alarm to bed when in bed. Observe and report to Nurse Adverse consequences of alarm use which can include, but are not limited to: fear, anxiety, or agitation related to the alarm sound; decreased mobility; sleep disturbances; and infringement on freedom of movement, dignity, and privacy Date Initiated: 11/26/2023 An observation of Resident #65 on 05/2/24 at 4:19 PM found the fall mats at her bed side had an over the bed table and oxygen concentrator parked on them. This was confirmed the invention preventions at the time of the observation. She confirmed the fall mats should not have items parked on them. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An additional observation of Resident #65 on 06/04/24 at 1:55 PM found the residents bed alarm was in place however the pressure sensing pad was not plugged into the alarm. Therefore it would not have alarmed had the resident attempted to get out of bed this was confirmed with Nurse Aide #44 at the time of the observation. She stated, I just came out of there and did not notice that because I was on the other side of the bed. A final observation of Resident #65 at 9:15 am on 06/05/24 found Resident #65 was again in bed. The alarm pad was on the residents bed and the alarm was hanging on the assist rail. However upon a closer observation it was discovered the pad was once again not connected to the alarm and would not have alarmed had the resident attempted to get out of bed. This was confirmed with Licensed Practical Nurse (LPN) # 121 at the time of the observation . 49467 49751

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 49465 Based on observation, staff interview, and record review the facility failed to provide activities of daily living (ADL) to dependent residents to maintain good personal hygiene. This failed practice was found true for (1) one of (6) six residents looked at for ADL care area during the Long-Term Care Survey Process. Resident identifier #45. Facility Census 111. Findings include: An observation on 06/03/24 at 11:48 AM, revealed Resident #45 had chin hair that was approximately 3 centimeters long and covered most of her chin. During an interview on 06/03/24 at 12:12 PM, with Resident #45 she stated, These chin hairs bother me sometimes, They don't always shave them. My nails were really long and they just cut them the other day. During an interview on 06/03/24 at 12:20 PM, Nurse Aide (NA) #110 stated, I did her care today, sometimes she refuses some of her care. I don't know when the last time she had her chin hair shaved. A record review on 06/03/24 at 12:48 PM, of Resident #25's task titled {AM CARE} revealed that residents scheduled shower days are Monday, Wednesday and Friday. For the past 30 days it shows no refusals of care. Further record review shows no care plan for refusals of care. During an interview on 06/03/24 at 1:45PM, with The Director of Nursing (DON), she confirmed that Resident #45's chin hairs should have been shaved.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 49751 Based on observation, and interviews the facility faild to provide an activity program calendar that is clearly visible. This was a random opportunity for discovery and had the potential to affect more than a limited number of residents. Facility Census: 111 Resident identifier: #16 Findings include: On 06/03/24 at 1:04 PM two surveyors observed the May activity program calendar hanging on the wall near the main dining room and activity office. The activity program calendar was observed to be written in the following colors; bright orange, lime green, hot pink, and purple, the activities scheduled was not easily read due to the bright/neon colors by either surveyor making this observation. An interview with Resident #16 on 06/03/24 at 1:30 PM revealed the rsident could not make out what was on the calendar stating them colors are bright aint they, glasses or no glasses you couldn't read that. On 06/03/24 at 1:40 PM, the Activity Director stated oh ok I will get this changed confirming the colors were bright and making the activity program's schedule not easily read.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 31826 Based on record review and staff interview, the facility failed to follow physician's orders for medication administration. This was true for five (5) of five (5) residents reviewed during the survey process. Resident Identifier: #15, #85, #19, #57 and #361. Facility Census: 111. Findings Include: a) Resident #15 On 06/04/24 at 11:25 AM, a record review was completed for Resident #15. The review found the Medication Administration Record (MAR) for May, 2024 had not been initialed off by the nurse and were left blank, which indicates the medication was not administered as ordered. The following medications are as follows: --Melatonin 3mg (milligram) give two tablets at bedtime was ordered for 05/17/24 at 9:00 PM --Singular 10mg give one tablet at bedtime was ordered for 05/17/24 at 9:00 PM --Mupirocin External Ointment 2% (percent) apply to bilateral nares topically at bedtime was ordered for 05/17/24 at 9:00 PM --Nicotine Transdermal Patch apply one patch transdermally at bedtime and remove per schedule was ordered for 05/17/24 remove at 8:59 PM and apply at 9:00 PM --Seroquel XR (extended release) 150mg give one tablet at bedtime was ordered for 05/17/24 at 9:00 PM --Ativan 1mg give one tablet two times daily was ordered for 05/17/24 at 9:00 PM --Neurontin 800mg give one tablet three times daily was ordered for 05/17/24 at 9:00 PM --Hydralazine 25mg give one tablet three times daily was ordered for 05/17/24 at 9:00 PM --Levothyroxine 50mcg (microgram) give one tablet in the morning was ordered for 05/27/24 at 6:00 AM --Pantoprazole 40mg give one tablet in the morning was ordered for 05/27/24 at 6:00 AM --Neurontin 800mg give one tablet three times daily was ordered for 05/27/24 at 6:00 AM --Hydralazine 50mg give one tablet three times daily was ordered for 05/27/24 at 6:00 AM --Melatonin 3mg give two tablets at bedtime was ordered for 05/30/24 at 9:00 PM --Singular 10mg give one tablet at bedtime was ordered for 05/30/24 at 9:00 PM (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Mupirocin External Ointment 2% apply to bilateral nares topically at bedtime was ordered for 05/30/24 at 9:00 PM --Nicotine Transdermal Patch apply one patch transdermally at bedtime and remove per schedule was ordered for 05/30/24 remove at 8:59 PM and apply at 9:00 PM --Seroquel XR 150mg give one tablet at bedtime was ordered for 05/30/24 at 9:00 PM --Advair Diskus Inhalation Aerosol Powder Breath Activated 250-50mcg/ACT 1 puff inhale orally two times daily was ordered for 05/30/24 at 9:00 PM --Eliquis 5mg give one tablet two times daily was ordered for 05/30/24 at 9:00 PM --Buspar 30mg give one tablet two times daily was ordered for 05/30/24 at 9:00 PM --Flecainide 100mg give one tablet two times daily was ordered for 05/30/24 at 9:00 PM --Guaifenesin ER 600mg give two tablets two times daily was ordered for 05/30/24 at 9:00 PM --Ativan 1mg give one tablet two times daily was ordered for 05/30/24 at 9:00 PM --Miralax 17 grams give 17 grams two times daily was ordered for 05/30/24 at 9:00 PM --Neurontin 800mg give one tablet three times daily was ordered for 05/30/24 at 2:00 PM --Neurontin 800mg give one tablet three times daily was ordered for 05/30/24 at 10:00 PM --Hydralazine 50mg give one tablet every 8 hours was ordered for 05/30/24 at 2:00 PM --Hydralazine 50mg give one tablet every 8 hours was ordered for 05/30/24 at 10:00 PM --Cyanocobalamin 1000mcg give one tablet daily was ordered for 05/31/24 at 9:00 AM --Flonase Allergy Relief Nasal Suspension give 1 spray in both nares daily was ordered for 05/31/24 at 9:00 AM --Furosemide 20mg give one tablet daily was ordered for 05/31/24 at 10:00 AM --Isosobide Mononitrate ER 60mg give one tablet daily was ordered for 05/31/24 at 9:00 AM --Lactulose Oral Suspension 20mg/30ml give 30ml daily was ordered for 05/31/24 at 9:00 AM --Levothyroxine 50mcg give one tablet in the morning was ordered for 05/31/24 at 9:00 AM --Loratadine 10mg give one tablet daily was ordered for 05/31/24 at 9:00 AM --Melatonin 3mg give two tablets at bedtime was ordered for 05/31/24 at 9:00 PM (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Singular 10mg give one tablet at bedtime was ordered for 05/31/24 at 9:00 PM --Mupirocin External Ointment 2% apply to bilateral nares at bedtime was ordered for 05/31/24 at 9:00 PM --Nicotine Transdermal Patch apply one patch transdermally at bedtime and remove per schedule was ordered for 05/31/24 remove at 8:59 PM and apply at 9:00 PM --Pantoprazole 40mg give one tablet in the morning was ordered for 05/31/24 at 6:00 AM --Potassium Chloride ER 20meq (milliequivalant) give two tablets daily was ordered for 05/31/24 at 9:00 AM --Sentry Adult Tablet give one tablet daily was ordered for 05/31/24 at 9:00 AM --Seroquel XR 150mg give one tablet at bedtime was ordered for 05/31/24 at 9:00 PM --Toprol XL 25mg give one tablet daily was ordered for 05/31/24 at 10:00 AM --Trelegy Ellipta Inhalation Aerosol Powder Breath Activated 200-62.5-25mcg/ACT 1 puff inhale orally daily was ordered for 05/31/24 at 9:00 AM --Venlafaxine 100mg give one tablet in the morning was ordered for 05/31/24 at 9:00 AM --Advair Diskus Inhalation Aerosol Powder Breath Activated 250-50mcg/ACT 1 puff inhale orally two times daily was ordered for 05/31/24 at 9:00 AM --Advair Diskus Inhalation Aerosol Powder Breath Activated 250-50mcg/ACT 1 puff inhale orally two times daily was ordered for 05/31/24 at 5:00 PM --Eliquis 5mg give one tablet two times daily was ordered for 05/31/24 at 9:00 AM --Eliquis 5mg give one tablet two times daily was ordered for 05/31/24 at 5:00 PM --Buspar 30mg give one tablet two times daily was ordered for 05/31/24 at 9:00 AM --Buspar 30mg give one tablet two times daily was ordered for 05/31/24 at 5:00 PM --Flecainide Acetate 100mg give one tablet two times daily was ordered for 05/31/24 at 9:00 AM --Flecainide Acetate 100mg give one tablet two times daily was ordered for 05/31/24 at 5:00 PM --Guaifenesin ER 600mg give two tablets two times daily was ordered for 05/31/24 at 9:00 AM --Guaifenesin ER 600mg give two tablets two times daily was ordered for 05/31/24 at 5:00 PM --Ativan 1mg give one tablet two times daily was ordered for 05/31/24 at 9:00 AM (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Ativan 1mg give one tablet two times daily was ordered for 05/31/24 at 9:00 PM --Polyethylene Glycol 17 grams give 17grams two times daily was ordered for 05/31/24 at 9:00 AM --Polyethylene Glycol 17 grams give 17 grams two times daily was ordered for 05/31/24 at 5:00 PM --Gabapentin 800mg give one tablet three times daily was ordered for 05/31/24 at 6:00 AM --Gabapentin 800mg give one tablet three times daily was ordered for 05/31/24 at 2:00 PM --Gabapentin 800mg give one tablet three times daily was ordered for 05/31/24 at 10:00 PM --Hydralazine 50mg give one tablet three times daily was ordered for 05/31/24 at 6:00 AM --Hydralazine 50mg give one tablet three times daily was ordered for 05/31/24 at 2:00 PM --Hydralazine 50mg give one tablet three times daily was ordered for 05/31/24 at 10:00 PM On 06/05/24 at 9:30 AM, the Director of Nursing (DON) was interviewed regarding the medication which was not administered per physician's orders. The DON stated, Maybe the nurses were having problems with the wifi. The DON was asked, do they use down time forms? The DON responded, I'll have to check. On 06/05/24 at 9:40 AM, Licensed Practical Nurse (LPN) #121 and LPN #37 were asked, what do you do if you are unable to document your medication administration if the system is down? LPN #121 and #37 stated, if I cannot document in the computer and it has been one (1) hour, I will document on our downtime forms. On 06/05/24 at 9:48 AM, the down time paper MARs were reviewed for Resident #15. There was no evidence of any documentation for the above medications on the down time paper MARs. On 06/05/24 at 10:00 AM, the DON was notified of the medications and not finding any downtime documentation. The DON nodded her head and did not make any comment. b) Resident #85 On 06/04/24 at 9:13 AM, while observing medication administration, Resident #85 stated, I want my medication now. LPN #26 stated, (Name of Resident) let me get them for you. Upon opening the MAR in the computer, the medications were noted to be given at 9:09 AM. LPN #26 was asked, why does the computer show the medication has already been given? LPN #26 stated, I haven't given his medication this morning .I don't know why it is checked off. LPN #26 stated, let me look and see who documented them. It was me. stated LPN #26. I know how I can check .let me look at the narcotic book and see if the Klonopin has been signed out. Upon reviewing the narcotic book, the Klonopin had not been signed out and the count was correct for the Klonopin. On 06/04/24 at 9:30 AM, LPN #26 approached this surveyor and stated, I know what happened .he wanted to go smoke .I must have checked the medication off before I knew he was going to smoke. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Upon further review of the MAR, a physician's order for Toprol XL 100mg was found to have specific directions to check the resident's pulse before administering the medication. LPN #26 did not check the resident's pulse prior to administering the medication. On 06/04/24 at 9:45 AM, an interview was held with the DON. The DON was advised the medicaiton for Resident # 85 medication was documented at 9:09 AM when the resident did not receive the medication until 9:13 AM. The DON nodded her head and made no comment. c) Resident #19 A review of Resident #19's physician orders on 06/03/24 found the resident was to receive one (1) container of two (2) cal, a 60 milliliter flush of water before administering the feeding and/or medications, and a 200 milliliter flush of water following the administration of the feeding. These orders were all due at 11:00 am on 06/03/24. Licensed Practical Nurse (LPN) #121 was observed providing Resident #19's 11:00 AM feeding on 06/04/24 at 11:40 PM. LPN #121 took into the room the container of two cal along with a cup with 200 milliliters of water in it. She then poured a portion of the water down the tube after she checked the residual. She then set the cup with water to the side and administered the container of two cal. LPN #121 then administered the remaining water using the residents feeding tube. An interview with LPN #121 at 12:35 PM on 06/04/24 confirmed she did not give Resident #19 the 60 milliliter flush as ordered. She stated I just used some of the 200 milliliters of water. d) Resident #57 A review of the medication administration audit report for Resident #57 for the month of 05/2024 found on the following occasions Resident #57's medications were administered outside of the physician prescribed time frames: -- On 05/03/24 Resident #57 was ordered Insulin Detemir 10 units. This was due to be administered at 9:00 PM but was not administered until 05/04/24 at 2:15 AM which was five (5) hours and 15 minutes late. -- On 05/03/24 Resident #57 was ordered Alprazolam 1 mg. This was due to be administered at 10:00 PM but was not administered until 05/04/24 at 2:15 AM which was four (4) hours and 15 minutes late. -- On 05/03/24 Resident #57 was ordered Atorvastatin. This was due to be administered at 10:00 PM but was not administered until 05/04/24 at 2:15 AM which was four (4) hours and 15 minutes late. -- On 05/09/24 Resident #57 was ordered novolog Inject per sliding scale. This was due to be administered at 6:00 AM but was not administered until 7:30 am which was one (1) and one (1) half hour late. -- On 05/10/24 Resident #57 was ordered novolog Inject per sliding scale. This was due to be administered at 6:00 AM but was not administered until 7:11 am which was one (1) and 11 minutes late. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-- On 05/10/24 Resident #57 was ordered Gabapentin Oral Capsule 400 milligrams(MG). This was due to be administered at 6:00 AM but was not administered until 7:11 am which was one (1) and 11 minutes late. -- On 05/10/24 Resident #57 was ordered synthroid 150 mcg. This was due to be administered at 6:00 AM but was not administered until 7:11 am which was one (1) and 11 minutes late. -- On 05/10/24 Resident #57 was ordered Alprazolam 1 mg. This was due to be administered at 6:00 AM but was not administered until 7:11 am which was one (1) and 11 minutes late. -- On 05/15/24 Resident #57 was ordered synthroid 150 mcg. This was due to be administered at 6:00 AM but was not administered until 12:03 PM which was six (6) hours and three (3) minutes late. -- On 05/15/24 Resident #57 was ordered Alprazolam 1 mg. This was due to be administered at 6:00 AM but was not administered until 12:03 PM which was six (6) hours and three (3) minutes late. -- On 05/15/24 Resident #57 was ordered gabapentin. This was due to be administered at 6:00 AM but was not administered until 12:03 PM which was six (6) hours and three (3) minutes late. An interview with Registered Nurse (RN)#4 at 10:15 am on 06/05/24, confirmed these medications were administered late. e) Resident #361 At approximately 11:00 AM on 06/04/24, during a review of the Medication Administration Record (MAR) for Resident #361, a blank space was noted for the 2:00 PM medication pass on 05/29/24 for the resident's Norco Oral Tablet 5-325 MG and Zinc Sulfate Capsule 220. At approximately 12:00 PM on 06/04/24, an interview was conducted with the Director of Nursing regarding the missing medication on the MAR for that day. The DON stated I ' m not sure if the internet was down that day or not, if it was, they should use the paper sheets to document the medications given while the internet is down. At approximately 12:10 PM on 06/04/24, an interview was conducted with Licensed Practical Nurse (LPN) #26 regarding the paper sheets for the medication pass that day. LPN #26 was unable to produce any paper documentation related to that particular medication pass. At approximately 12:40 PM on 06/04/24, the DON stated they were unable to provide any additional documentation to prove the medication was given that day. 45173 49467

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31826 Based on observation, record review, and staff interview, the facility failed to ensure the resident environment, over which it had control, was as free of accident hazards as possible, by leaving the Central Supply room door open, and the cabinet inside the Central Supply room unlocked, exposing residents to hazards that could potentially cause serious injury or death. This was a random opportunity for discovery. Resident identifier: 91, 73, 95, 106, 70, 30 and 65. Facility census: 111. The State Agency (SA) determined these failures put the residents residing in the facility at risk for serious harm/death due to residents in the facility having access to the Central Supply room which contained potentially hazardous chemicals that could be ingested, and needles and scalpels that could cause serious injury or death. This placed all residents in the facility in an Immediate Jeopardy (IJ) situation. The facility was first notified of the IJ at 1:03 PM on 05/30/24, The SA received the Plan of Correction (POC) at 5:05 PM on 05/30/24. The SA accepted the POC at 5:05 on 05/30/24. The IJ was abated at 3:30 PM 06/05/24. After the IJ was removed, a deficient practice remained due to Resident #30 having cigarettes at their bedside, and due to the facility failing to implement fall interventions for Resident #65. Therefore the scope and severity was decreased from a k to a e after the IJ was abated. Findings include: A1) Observation At approximately 2:50 PM on 05/29/24, Resident #91 was observed wandering on the east wing of the facility. Resident #91 attempted to enter the Central Supply room multiple times, attempting to turn the handle to open the door, however the door was locked. At approximately 9:45 PM on 05/29/24, during a tour of the facility, the door to the Central Supply room, located on the east side of the facility, was discovered to be open. Five (5) staff members were observed at the East nurse station eating pizza. When the staff members noticed the surveyor in the building, one (1) staff member stood up with the pizza box and walked past the open Central Supply door to discard the pizza box, and did not attempt to close the Central Supply door. Upon entering the Central Supply room, the following was discovered on the shelves accessible to residents : One case of disposable razors Eight orange sticks (sharp sticks used to clean under fingernails) Two bottles of isopropyl rubbing alcohol Labeled reads Keep out of reach of children. If swallowed, get medical help or contact a poison control center right away (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Seventeen bottles of povidone iodine prep solution Labeled reads Keep out of reach of children. If swallowed, get medical help or contact a poison control center right away Five bottles of hydrogen peroxide Labeled reads Keep out of reach of children. If swallowed, get medical help or contact a poison control center right away Twelve bottles of hand sanitizer Labeled reads Keep out of reach of children. If swallowed, get medical help or contact a poison control center right away Eight bottles of antiperspirant deodorant spray Labeled reads Keep out of reach of children. If swallowed, get medical help or contact a poison control center right away Nine fleet saline enemas Labeled reads Keep out of reach of children. If swallowed, get medical help or contact a poison control center right away Eight bottles of hair conditioner Labeled reads Keep out of reach of children. If swallowed, get medical help or contact a poison control center right away Nineteen bottles of body lotion Labeled reads Keep out of reach of children. If swallowed, get medical help or contact a poison control center right away Five bottles of perineal cleanser Labeled reads Keep out of reach of children. If swallowed, get medical help or contact a poison control center right away Seven bottles of aftershave lotion Labeled reads Keep out of reach of children. If swallowed, get medical help or contact a poison control center right away Eight bottles of listerine mouthwash (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Labeled reads Keep out of reach of children. If swallowed, get medical help or contact a poison control center right away Upon further investigation, a cabinet in the back of the central supply room was discovered to be unlocked. The following items were discovered in the cabinet: One case of 25 gauge by five eighths of an inch tuberculin syringes with needles Two cases of 27 gauge by one half inch tuberculin syringes with needles One box of ten stainless steel scalpels One bottle of Gentian [NAME] topical solution Labeled reads Keep out of reach of children. If swallowed, get medical help or contact a poison control center right away Two bottles of Dakins Half Strength Solution Labeled reads Keep out of reach of children. If swallowed, get medical help or contact a poison control center right away Two bottles of Caldesene Medicated Powder Labeled reads Keep out of reach of children. If swallowed, get medical help or contact a poison control center right away Two boxes of glucose monitor control solution Labeled reads Keep out of reach of children. If swallowed, get medical help or contact a poison control center right away Ten cases of safety lancets Two cases of 100 insulin syringes Two cases and a one gallon ziplock bag of safety glide needles One box of vacutainer blood collection kit Two boxes of auto shield pro lancets One box of filter needles with five micron filters One box labeled Needles Different Sizes contained 25 gauge by five eighths inch needles and 18 gauge by one inch hypodermic safety needles. Five boxes of sheathed IV catheters (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	One case of BioFreeze packets Labeled reads Keep out of reach of children. If swallowed, get medical help or contach a poison control center right away Nine tubes of Selan Plus Zinc Oxide Formula Labeled reads Keep out of reach of children. If swallowed, get medical help or contact a poison control center right away 12 tubes of calmoseptine ointment Labeled reads Keep out of reach of children. If swallowed, get medical help or contact a poison control center right away Four cases of calmoseptine ointment packets Labeled reads Keep out of reach of children. If swallowed, get medical help or contact a poison control center right away Two bottles of Sting Free Liquid Skin Prep and Shield Labeled reads Keep out of reach of children. If swallowed, get medical help or contact a poison control center right away Four bottles of Skin Prep protective spray Labeled reads Keep out of reach of children. If swallowed, get medical help or contact a poison control center right away A2) Staff interview On 05/29/24 at approximately 9:58 PM, Nurse Aide (NA) #40 entered the Central Supply room. NA #40 was asked if the door to Central Supply was usually left open and they stated I don ' t think so, at least it shouldn ' t be. On 05/29/24, at approximately 10:03 PM, an interview was conducted with Licensed Practical Nurse (LPN) #26. LPN #26 was asked if the door to Central Supply was usually left open on night shift, to which LPN #26 replied, Maintenance was cleaning the floors and probably left it open. When LPN #26 was asked about the unlocked cabinet they stated, That ' s where we keep all of our needles. It was probably unlocked because the nurse came in here to get something and then other staff yelled at her and she just left the room and left it unlocked. A3) Record review On 05/30/24 at approximately 9:10 AM a list of wanderers on the east wing of the facility was requested from the Director of Nursing (DON). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	At approximately 9:20 AM the DON supplied a list of residents on the east wing with the wanderers highlighted. The following residents were identified by the facility as wanderers on the east wing: Resident #91 Resident #73 Resident #95 Resident #106 Resident #70 A4) Plan of Correction The facility ' s POC was accepted at 5:05 PM on 05/30/24 and the IJ was abated at 3:30 PM on 06/05/24. The POC is typed as written: 1.) On 5/30/2024, the administrator ensured that all razors, needles, scalpels, medicated powders, creams, and any other solution if consumed could be harmful was moved from the Central Supply Room to the East Wing Medication Room. On 5/30/2024 all staff were informed that the items were relocated and even though those items are being placed elsewhere the Central Supply Room door is to remain closed at all times and locked. 2.) Because this has the potential to affect all residents, on 5/30/2024 video footage with full view of the Central Supply Room door was reviewed to ensure no residents entered the room for potential to have consumed any toxic substance with any corrective action immediately upon discovery. 3.) The administrator completed an in-service for all staff to ensure they are aware that the Central Supply Room door is to remain closed and locked at all times and the new location of the potentially harmful substances in the East Wing Medication Room. All staff will be in-serviced as of 5/30/2024 prior to their next shift, and virtually if need be. 4.) The Administrator will ensure adherence to the Keeping Residents Free from Potentially Harmful Substances and Items Policy and Procedure, ensure that staff keep all doors locked and all substances out of reach as appropriate. A monitoring log will be completed to ensure that all doors with locks are locked and all potentially harmful substances are kept in a safe area of of residents reach daily for 30 days, weekly for one month, and quarterly thereafter. To ensure continued compliance, the monitoring log will be re-evaluated at the Quarterly and Quality Assurance meeting. b) Resident #30 An observation on 06/04/24 at 12:00 PM, of Resident #30's room revealed, he had cigarettes at his bedside, sitting on top of his bedside dresser. During an interview on 06/04/24 at 12:00PM, Resident #30 stated, It's almost smoke time. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A record review on 06/04/24 of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/25/24 section C for Resident #30 revealed a Brief Interview for Mental Status (BIMS) score of 99. Further record review revealed the following care plan focus for Resident #30: Focus: {Initiated on 05/09/24} Typed as written. - Memory problems / dementia - is not aware of his surroundings or safety needs. Focus: {Initiated on 05/29/24} The resident is a wanderer AEB -Disoriented to place at times -Resident wanders at times During an observation on 06/04/24 at 1:00PM of the [NAME] Wing where Resident #30 resides in room [ROOM NUMBER]-B revealed (2) two other residents that wander. Resident #94 and Resident #77. A record review on 06/04/24 at 1:30PM, revealed that Resident #94 has a diagnosis of Alzheimer's. Further record review revealed the following care plan focus for Resident #94: Focus: {Revised on 05/17/24} Typed as written. -The resident is at risk for falls r/t -H/O falls -Unsteady -Lacks safety awareness -Restless at times, frequently repositions self in bed/chair -Med use -poor balance -poor cognition -is ambulatory throughout facility and (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	wanders in and out of rooms. A record review on 06/04/24 at 1:40 PM, revealed that Resident #72 has a diagnosis of unspecified Dementia with other behavioral disturbances. Further record review revealed the following care plan focus for Resident #77: Focus: {Revised on 05/29/24} The resident is an elopement risk/wanderer AEB -Confusion -Disoriented to place -Impaired safety awareness A review on the Federal Drug Administration (FDA) warning for Nicotine 06/04/24 at 2:15PM, read as follows: Nicotine, the addictive ingredient in tobacco, is not safe - whether it is eaten, touched or inhaled. Symptoms of mild nicotine poisoning include stomach problems like nausea, vomiting and diarrhea. More severe cases can include dizziness, sweating, headache, hyperactivity or restlessness. During an interview on 06/04/24 at 2:30PM, Registered Nurse (RN) #4 stated, We used to keep the cigarettes locked up, but residents complained and wanted to keep their own. That is why they do it that way now. I will talk to them. It will be hard to get them to agree to lock them up again. c) Resident #65 A review of Resident #65's care plan on the afternoon of 05/28/24 found the following care plan related to fall prevention: Focus Statement Read: - The resident is at risk for falls r/t (Related To) -Not aware of safety needs -H/O (History of) falls at home was in floor on 12/12/23 in floor 3/10/24 was off matt in floor slid out of chair on 3/18/24 Date Initiated: 11/21/2023 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Revision on: 03/19/2024 The goal related to this focus statement read as follows: --The resident will be free of falls through the review date. Date Initiated: 05/14/2024 Revision on: 05/17/2024 Target Date: 08/15/2024 The Interventions related to this goal included: -- Safety mat to bilateral side(s) of bed d/t safety precaution, risk of falls. Date Initiated: 12/19/2023 Revision on: 12/29/2023 -- Dycem to w/c at all times to prevent sliding. Date Initiated: 05/28/2024 -- Alarm to chair while in chair. Observe and report to nurse Adverse consequences of alarm use which can include, but are not limited to: fear, anxiety, or agitation related to the alarm sound; decreased mobility; sleep disturbances; and infringement on freedom of movement, dignity, and privacy -- Alarm to bed when in bed. Observe and report to Nurse Adverse consequences of alarm use which can include, but are not limited to: fear, anxiety, or agitation related to the alarm sound; decreased mobility; sleep disturbances; and infringement on freedom of movement, dignity, and privacy Date Initiated: 11/26/2023 An observation of Resident #65 on 05/2/24 at 4:19 PM found the fall mats at her bed side had an over the bed table and oxygen concentrator parked on them. This was confirmed the invention preventions at the time of the observation. She confirmed the fall mats should not have items parked on them. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An additional observation of Resident #65 on 06/04/24 at 1:55 PM found the residents bed alarm was in place however the pressure sensing pad was not plugged into the alarm. Therefore it would not have alarmed had the resident attempted to get out of bed this was confirmed with Nurse Aide #44 at the time of the observation. She stated, I just came out of there and did not notice that because I was on the other side of the bed. A final observation of Resident #65 at 9:15 am on 06/05/24 found Resident #65 was again in bed. The alarm pad was on the residents bed and the alarm was hanging on the assist rail. However upon a closer observation it was discovered the pad was once again not connected to the alarm and would not have alarmed had the resident attempted to get out of bed. This was confirmed with Licensed Practical Nurse (LPN) # 121 at the time of the observation . 49465 49467

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 49467 Based on record review and resident and staff interview, the facility failed to ensure each resident received proper hydratio, due to no water being passed to Resident #27. This was true for one (1) of two (2) residents reviewed for hydration during the survey process. Resident identifier: 27. Facility census: 111. Findings include: A) Resident #27 At approximately 2:43 PM on 05/28/24 an interview was conducted with Resident #27. She stated I don't get juice and snacks like I used to. My mouth is so dry, it feels like I ' m spitting cotton. Resident #27 was asked if facility staff passed water and ice on a daily basis, to which they stated No, they don ' t pass it. No water pitcher was witnessed within reach of Resident #27. Upon further investigation, no water pitcher was found in Resident #27 ' s room. Another observation of Resident #27 ' s room at approximately 12:51 PM on 05/29/24 revealed no water pitcher was present in the room. At approximately 10:00 AM on 05/30/24 another observation of Resident #27 ' s room revealed no water pitcher was present in the room. At approximately 4:50 PM on 05/30/24, an observation of Resident #27 ' s room revealed no water pitcher was present in the room. A review of the care plan for Resident #27 revealed she is at risk for dehydration. The care plan states the following as a focus: The resident has dehydration or potential fluid deficit r/t (related to) N/V (nausea/vomiting) at times. The goal for this focus is: The resident will be free of symptoms of dehydration and maintain moist mucous membranes, good skin turgor. Listed under interventions and tasks is: Encourage/Cue resident to drink all fluid on meal tray and participate with juice wagon. At approximately 5:17 PM on 05/30/24, The Director of Nursing (DON) accompanied this surveyor to Resident #27 ' s room and acknowledged the absence of a water pitcher. An interview was then conducted with the DON regarding the absence of a water pitcher in Resident #27 ' s room. The DON stated I don ' t know if she can hold the regular water pitchers. When the DON was informed there were no orders for adaptive equipment for Resident #27, she stated I ' m not sure then, I would have to get back to you.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 49467 Based on record review and staff interview, the facility failed to ensure that yearly performance evaluations were completed for each nurse aide. This was true for two (2) of five (5) nurse aide performance evaluations reviewed during the survey process. Facility census: 111. Findings Include: A) Incomplete Evaluations At approximately 11:30 AM on 06/05/24, a review was conducted of nurse aide performance evaluations completed by the facility for the last year. During review, it was determined that two evaluations were incomplete. The evaluation for Nurse Aide (NA) #49 was filled out but there was no date indicating when the performance evaluation was completed. The evaluation for NA #48 did not have a complete characteristics portion of the evaluation. Under the characteristics portion, there are four (4) choices, unsatisfactory, satisfactory, good, excellent. None of the options were selected for that portion of the evaluation. The evaluation was also not dated to indicate when it was completed. At approximately 12:00 PM on 06/05/24 an interview was conducted with the Nurse Aide Supervisor (NAS) regarding the incomplete evaluations. The NAS acknowledged the incomplete evaluations and stated It was a mistake.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 49467 Based on record review and staff interview, the facility failed to ensure each resident ' s drug regimen was free of unnecessary psychotropic medications by prescribing Resident #27 an antipsychotic medication before showers. This was true for one (1) of five (5) residents reviewed for unnecessary medications during the survey process. Resident identifier: 27. Facility census: 111. Findings include: A) Record review At approximately 2:22 PM on 05/30/24, a record review was conducted of medication regimen reviews for Resident #27. During this review, the recommendation made on the review for May of 2023 was for Ziprasidone. The recommendation stated the diagnosis of dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance should be changed to be more specific, or the medication should be discontinued. The order for the medication read: Geodon Intramuscular Solution Reconstituted (Ziprasidone Mesylate) Inject 10 mg intramuscularly every day shift every Tue, Thu, Sat for Dementia with psychotic features administer 10mg injection IM x 1 20 min prior to shower. A review of the MAR for Resident #27 revealed she received the injection on the following days: -05/20/23 -05/23/23 -05/25/23 -05/27/23 -05/30/23 -06/01/23 -06/03/23 -06/06/23 -06/08/23 -06/10/23 -06/13/23 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-06/15/23 -06/20/23 -06/22/23 -06/24/23 -06/27/23 -06/29/23 -07/01/23 -07/04/23 -07/06/23 -07/08/23 -07/11/23 -07/13/23 -07/15/23 -07/18/23 B) Staff interviews At approximately 3:43 PM on 06/03/24 an interview was conducted with the Director of Nursing (DON) regarding the order for Ziprasidone to be given to Resident #27 before her showers. The DON stated That is the only way we could get her in the shower. She was combative, she would hit and scratch the staff, she was going to hurt herself or someone else if we didn ' t give it to her.

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	515140	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Health Care of Logan	1000 West Park Avenue Logan, WV 25601

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31826 Based on observation, resident interview, and staff interview the facility failed to serve food and drink that was palatable, attractive and at a safe and appetizing temperature. This failed practice was a random opportunity for discovery and had the potential to affect more than a limited number of residents currently residing at the facility. Facility Census: 111. Findings Include: A) Dining Room evening time meal. During an observation of the evening meal on 05/28/24 beginning at 6:00 PM it was noted staff from the units were bringing trays into the dining room and placing them in a meal cart that was in the dining room. This continued until the dining room meal cart arrived from the kitchen at approximately 6:20 PM. At this time they began serving 19 residents who had been waiting on their meal. At 6:30 PM when the last tray off the meal cart which was parked in the dining room at the beginning of the observation was served the Certified Dietary Manager was asked to obtain the temperature of the last tray. She did this at 6:30 PM and the following temperatures were obtained: -- Chicken [NAME] were 113.0 degrees Fahrenheit -- Mashed Potatoes was 117. 0 degrees Fahrenheit -- Milk was 54.8 degrees Fahrenheit The Dietary Manager confirmed these were out side of the acceptable temperatures required at the time of service. b) Resident #512 On 05/28/24 at 5:45 PM, the dinner service was observed on the [NAME] wing. The dinner tray was removed from food cart without a lid to cover the food. Nurse Aide (NA) #110 realized the plate did not have a cover and placed the contaminated tray back on the cart with clean trays. On 05/28/24 at 5:50 PM, Assistant Nurse Aide Supervisor #31 verified the tray should not have been placed back on the cart. On 05/28/24 at 5:55 PM, NA #110 returns to the [NAME] wing and placed the cover on the dining tray, and carried the tray down the hall to Resident #512. The resident was asked, is your food warm enough?' Resident #512 it is barely warm .it needs heated up. Nurse Aide #110 took the tray back down the hall and reheated the tray in the microwave. On 05/28/24 at 6:00 PM, Licensed Practical Nurse #34 was notified of the cold food being served to the resident. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/28/24 at 6:04 PM, the Administrator was notified of the cold food being served to the resident. The Administrator stated, I will talk with her. C) Resident #20 At approximately 2:20 PM on 05/28/24, an interview was conducted with Resident #20. Resident #20 stated The food is sometimes cold here. I don ' t think any of the staff here would want to eat cold food, so why should we? D) Resident #21 At approximately 2:20 PM on 05/28/24, an interview was conducted with Resident #21. During the interview, Resident #21 stated I ' m not sure why but the food seems like it is cold a good bit of the time. E) Resident #27 At approximately 2:43 PM on 05/28/24, an interview was conducted with Resident #27. During the interview, Resident #27 stated My food is cold almost all the time. I have complained about it but it seems like it hasn ' t helped. F) At approximately 2:48 PM on 05/28/24, an interview was conducted with Resident #72. During the interview, Resident #72 stated My food is cold here 45173 49467

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 45173 Based on observation, record review and staff interview, the facility failed to maintain an accurate and complete medical record for Resident #85, #95 and #58. This is true for three (3) of 32 residents reviewed during the survey process. Resident Identifier: #85 and #95. Facility Census: 111. Findings Include: a) Resident #85 On 06/04/24 at 9:13 AM, while observing medication administration, Resident #85 stated, I want my medication now. LPN #26 stated, (Name of Resident) let me get them for you. Upon opening the Medication Administration Record (MAR) in the computer, the medications were noted to be given at 9:09 AM. LPN #26 was asked, why does the computer show the medication has already been given? LPN #26 stated, I haven't given his medication this morning .I don't know why it is checked off. LPN #26 stated, let me look and see who documented them. It was me. stated LPN #26. I know how I can check .let me look at the narcotic book and see if the Klonopin has been signed out. Upon reviewing the narcotic book, the Klonopin had not been signed out and the narcotic count was correct for the Klonopin. On 06/04/24 at 9:30 AM, LPN #26 approached this surveyor and stated, I know what happened .he wanted to go smoke .I must have checked the medication off before I knew he was going to smoke. On 06/04/24 at 9:45 AM, an interview was held with the DON. The DON was advised the medicaiton for Resident # 85 medication was documented at 9:09 AM when the resident did not receive the medication until 9:13 AM. The DON nodded her head and made no comment. b) Resident #95 On 05/28/24 at 4:14 PM, a medical record review was completed for Resident #95. The review found the Physician's Scope of Treatment (POST) form dated 02/27/23 was listed as Do Not Resuscitate, Selective Treatments, no feeding tube. An additional POST form dated 03/08/23 was reviewed. The review found the POST form was listed as Do Not Resuscitate, Selective Treatments and no indication of whether the resident wanted a feeding tube or not. On 05/29/24 at 10:00 AM, the Director of Nursing (DON) was interviewed. The DON stated, I already updated the order for the most recent POST form which states no decision made for tube feeding. The physician's order dated 10/31/23 stated, Do Not Resuscitate, Selective Treatments, No feeding tube. The DON confirmed the physician's order was incorrect. No further information was obtained during the survey process. c) Resident #95 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #95's medical record found a post form dated 03/08/23 which was signed by Resident #95. However the section titled professional assisting in completion of the form was not completed. It was evident Resident #95 was assisted in completing the form because the handwriting was different than that of the Residents. An interview with Registered Nurse #4 at 1:45 pm on 06/06/24 confirmed they were not aware they needed to complete this section if the resident had capacity. 50801

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45173 Based on observation, record review and staff interview, the facility failed to maintain appropriate infection control standards for medication administration, disposal of soiled linen and dinner service. These were random opportunities for discovery. Resident Identifiers: #512, #85, and #13. Facility Census: 111. Findings Include: a) Resident #512 On 05/28/24 at 5:45 PM, observation of the dinner service was observed on the [NAME] wing. The dinner tray was removed from food cart without a lid to cover food. Nurse Aide (NA) #110 realized the plate did not have a cover and placed the contaminated tray back on the cart with clean trays. On 05/28/24 at 5:50 PM, Assistant Nurse Aide Supervisor #31 verified the tray should not have been placed back on the cart. On 05/28/24 at 6:00 PM, Licensed Practical Nurse (LPN) #34 was notified of the infection control breach during the dinner service. On 05/28/24 at 6:04 PM, the Administrator was notified of the infection control breach during the meal service. The Administrator stated, I will talk with her. b) Resident #85 On 06/04/24 at 9:00 AM, medication administration completed by LPN #26 was observed for Resident #85. LPN #26 did not use a barrier prior to sitting the medicine cup on the medication cart. On 06/04/24 at 9:04 AM, LPN #26 was notified no barrier was used prior to sitting the medicine cup on the medication cart. LPN #26 stated, I did forget didn't I. On 06/04/24 at 9:45 AM, the Director of Nursing (DON) nodded her head and did not make a comment. c) Resident #13 On 06/04/24 at 2:45 PM, 2:53 PM and 3:03 PM, observations were made of a soiled towel laying under the sink in Resident 13's bedroom. On 06/04/24 at 3:05 PM, Licensed Practical Nurse (LPN) #10 confirmed the linen should not be laying in the floor. d) room [ROOM NUMBER] An observation on 05/28/24 at 4:45 PM revealed used bunched up bed linen laying in room [ROOM NUMBER] under the sink during meal tray pass. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/28/24 at 5:05 PM surveyor observed Linen remained in floor of room [ROOM NUMBER]. On 05/28/24 at 6:02 PM the Administrator confirmed the linen should not have been laying in the floor and would make sure it is gotten up. 49751